

W2
A2
8F2195

RESTRICTED Security Information

UNCLASSIFIED (DOCUMENT SECTION)

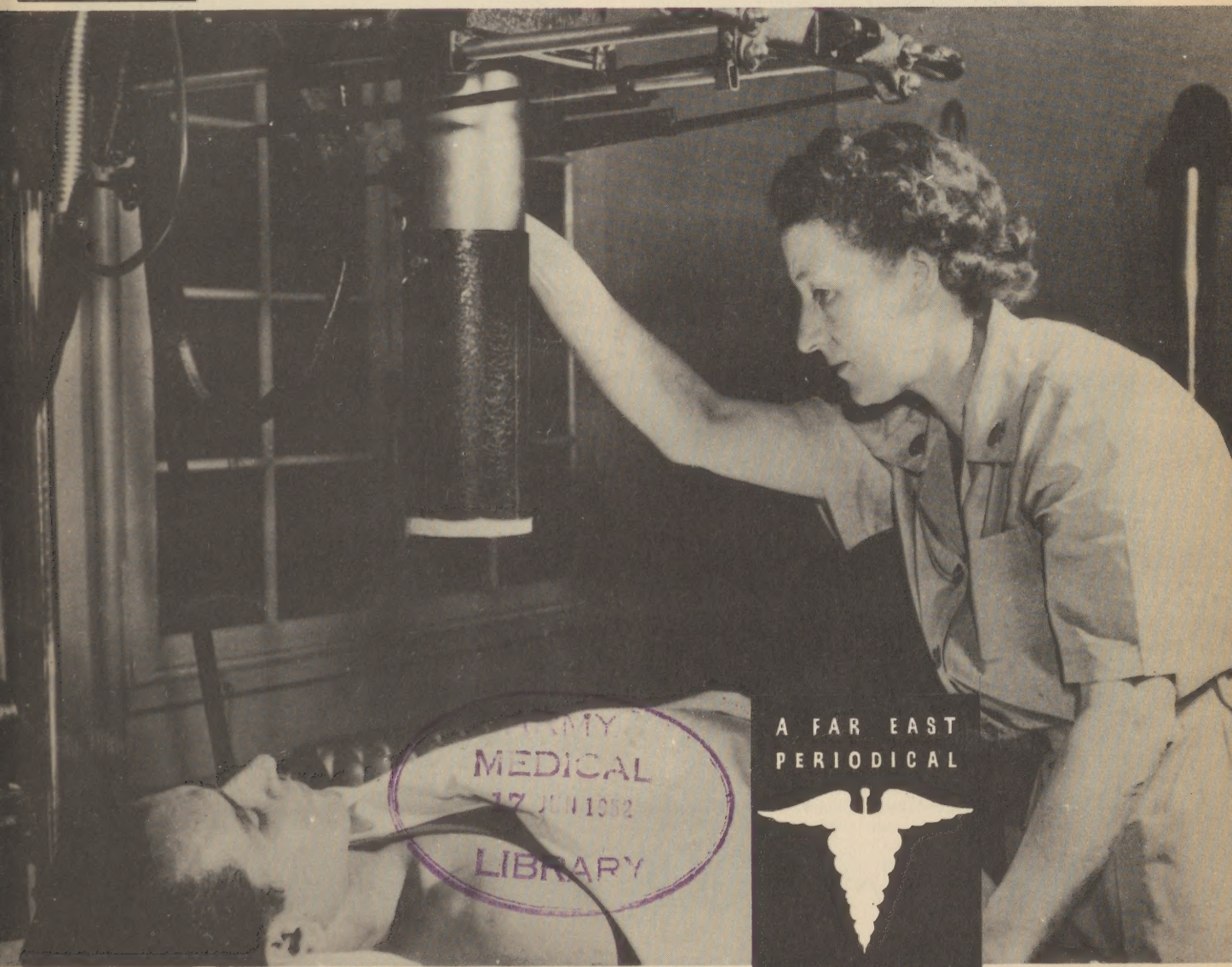
THE SURGEON'S

Circular Letter

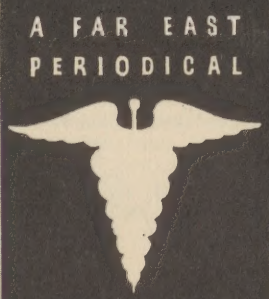
CLASSIFICATION CHANGED
TO UNCLASSIFIED
AUTH 1st Ind. Hq USAFFE
DATE 19 July 1954
SECURITY OFFICER
Frank H. Rogers

APR - 1952

VOLUME - VII
NUMBER - 4



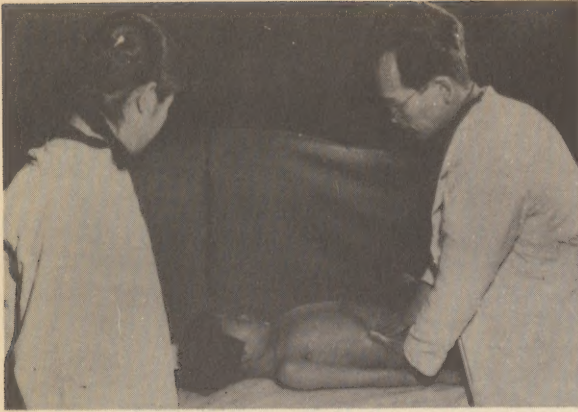
ARMY
MEDICAL
17 JUL 1952
LIBRARY



MEDICAL SECTION - HQ-FEC, AND UNC

APO 500

RESTRICTED Security Information



UNCACK doctor examines small child in hospital clinic in Chunchon while nurse at left assists



Nurses at the I Corps civilian hospital care for patient in hospital post operation ward



General view of the I Corps civilian hospital in Korea. Hosp. is entirely staffed by Koreans



Korean girls register mixed emotions as Dr Cho gives typhus shots at the 2d Div Civ Asst Sect



Korean physician examines aged Korean farmer who is being evacuated to a rear refugee area



Refugee getting a physical check as part of her processing under supervision 2d Div Civ Asst Sect

on the cover

Pvt Luis Bernal (Columbia) UN soldier, a patient at the US Army Hospital, Camp Yokohama, Yokohama, Japan, receives treatment from SFC Ester A. Tvetene, Co A, WAC Bn, 8064th AU, X-ray technician at the US Army Hospital, Camp Yokohama. (All photos by US Army Signal Corps)

THE SURGEON'S

Circular
LetterVolume VII - Number 4
APRIL, 1952
Headquarters,
Far East Command,
Medical Section
APO 500

ADMINISTRATIVE

Far East Command Medical Conference Held at Kyoto.	53
UNCACK Chief Nurse to Launch Nurses Training Program	53
Jutlandia Departs Far East Command	54
Appointment in Regular Army Medical Corps.	54
Recent Department of the Army and FEC Publications	56

FAR EAST COMMAND MEDICAL CONFERENCE HELD AT KYOTO

More than 175 medical officers attended the two-day Far East Command Medical Conference held in Kyoto 18-19 April under the auspices of the US Army Hospital, 8164th Army Unit.

Professional papers presented during the first day of the conference included "Cold Injuries for Winter of 1951-1952" by Lt Colonel Kenneth D. Orr, MC, Director, Cold Injury Research Team, Osaka Army Hospital; "Epidemic Hemorrhagic Fever" by Capt Julio Barbero, MC, 21st Evacuation Hospital; "Clinical Findings in 300 Cases of Epidemic Hemorrhagic Fever" by Colonel George M. Powell, MC, Chief, Medical Service, Osaka Army Hospital; "Experimental and Clinical Atherosclerosis" by 1st Lt Joseph P. Murphy, MC, US Army Hospital, Fukuoka; "Case Report on Xanthoma Diabeticorum" by 1st Lt Eser G. Margolin, MC, 382d General Hospital; "Acute Porphyria" by 1st Lt Charles M. Jennings, MC, 141st General Hospital; "Amebic Hepatitis" by Colonel Ryle A. Radke, MC, Chief, Medical Service, Tokyo Army Hospital; "Acute Opium Intoxication" by Capt Philip Troen, MC, Chief, Medical Service, US Army Hospital, Kobe; "Jaundice" by Capt George Bain, MC, 279th General Hospital; "Vector Electrocardiography" by Capt David J. Hughes, MC, Osaka Army Hospital; "Acute Myocardial Infarction and Subsequent Complications" by 1st Lt Eugene Gersch, MC, US Army Hospital, Sasebo; and "Rehabilitation of Medical Patients, With Special Reference to Epidemic Hemorrhagic Fever" co-authored by Colonel Arthur E. White, MC, Commanding Officer, US Army Hospital, Nara, and 1st Lt Hunter A. Soper, MC, US Army Hospital, Nara.

The second day of the conference was exclusively devoted to papers on infectious hepatitis. Papers included "Epidemiology of Infectious Hepatitis" by Colonel Joseph H. McNinch, MC, Consultant, Preventive Medicine, FEC; "Acute Infectious Hepatitis in the Far East Command" by Lt Colonel Robert E. Jordan, MC, Chief, Medical Service, US Army Hospital, Kyoto; "Treatment of Infectious Hepatitis" by Lt Colonel Tyron E. Huber, MC, Chief, Medical Service, US Army Hospital, Yokohama; "Vitamin B-12 in Treatment of Infectious Hepatitis" by Major Robert E. Campbell, MC, US Army Hospital, Kyoto; "A Statistical Evaluation of the Effects of Diet and Activity Upon the Course of Acute Infectious Hepatitis" by Richard D. Eckhardt, MC, Chief, Hepatitis Research Team, US Army Hospital, Kyoto.

The final activity on the program was a panel discussion on infectious hepatitis moderated by Colonel Ryle A. Radke, Lt Colonel Tyron E. Huber, and Lt Colonel Robert E. Jordan.

Those attending the conference were welcomed by Major General William E. Shambora, MC, Chief Surgeon, FEC, Brigadier General James P. Cooney, MC, Surgeon, Japan Logistical Command, and Colonel Sterrett E. Dietrich, MC, Commanding Officer, US Army Hospital, 8164th Army Unit.

The co-chairmen for the two-day meeting were Colonel Charles L. Leedham, MC, Consultant in Internal Medicine, FEC, and Colonel George M. Powell, MC.

UNCACK CHIEF NURSE TO LAUNCH NURSES TRAINING PROGRAM

Miss Susan Haines, of Hobart, Tasmania, Chief Nurse of the United Nations Civil Assistance Command, Korea, has announced that she will assist the ROK government in setting up an improved nurses training program and nursing organization. Miss Haines recently arrived in Korea from Geneva, Switzerland, via Tokyo. While in Tokyo she outlined some of the nursing

problems in Korea in a conference with the Chief Nurse, FEC, and representatives of the Japanese and Korean nursing profession.

Miss Haines stated that there are only 1,000 registered nurses in Korea at this time. Before the war there were over 1,600. Midwives, of course, are not

licensed nurses.

One of the problems in Eastern countries, she added, is that women are cut off from the nursing profession when they marry. The UNCACK Chief Nurse said the immediate need is to find a way to train more nurses without upsetting the present professional program there. "We hope to introduce foreign nurses into Korea to help out until the country can turn out a sufficient number of its own graduates," Miss Haines said.

The cooperation of Japanese nursing officials is being sought because Japan is the nearest country to Korea and the nursing patterns in the two countries follow nearly the same lines.

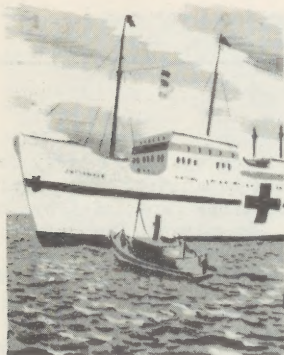
Miss Haines was formerly Chief Nurse of the Interna-

tional Refugee Organization in Europe, and before that Chief Nurse of the United Nations Relief and Rehabilitation Agency.

Attending the conference at the FEC Medical Section were Lt Colonel Alice M. Gritsavage, ANC, Chief Nurse, FEC, Miss Natsue Inouye, President of the Japanese Nursing Profession, Miss Mitsu Kaneko, Chief of the Nursing Section, Japanese Ministry of Welfare, Mrs. Inai Yang, Welfare Attache of the Korean Mission, and Dr. Anna R. Manittoff, Chief of Medical Services, Public Health and Welfare Division, FEC.

Miss Kaneko and Mrs. Yang hold degrees in nursing education from Yale and Vanderbilt Universities, respectively.

JUTLANDIA DEPARTS FAR EAST COMMAND



General and Mrs. Matthew B. Ridgway bade farewell to 184 sick and wounded United Nations soldiers from six nations on 21 April, prior to their departure for their homelands aboard the Danish hospital ship, "Jutlandia."

Patients aboard the Jutlandia included 72 Ethiopians, 75 Turks, 12 Greeks, 7 Frenchmen, 9 Belgians, and 9 members of the Netherlands' Forces.

This is the second international mercy voyage for the Jutlandia since joining UN Forces in the Far East on 2 March 1951. Her first departure was on 1 August 1951 when she took 205 sick and wounded men from seven nations to their homelands. The Jutlandia returned to the Far East on 7 November 1951.

Pledged by Denmark to serve at least one year in sup-

port of the Korean campaign, the Jutlandia was chartered from the East Asiatic Company by the Danish government one month after the outbreak of hostilities in Korea. It is a former cargo-passenger vessel that sailed between Copenhagen and New York and was converted to a modern, well-equipped hospital ship. The government of Denmark appropriated nearly \$1,000,000 for conversion of the vessel and an additional \$2,000,000 to pay for medicines, supplies, equipment and maintenance costs.

The hospital staff comprises 100 people including 16 doctors, 40 nurses, 25 orderlies, one chaplain, and other administrative and technical assistants. All are civilian volunteers chosen by the Danish government from more than 3,000 applicants.

The first stop for the Danish ship after it left Yokohama was Singapore, on 1 May. Other stops include Aden, Djibouti, Istanbul, Piraeus, Naples, Marseilles, Antwerp, and its final destination will be Copenhagen, on 6 June. The ship's commander is Commodore Kai Hammerich, who is a member of the Royal Danish Navy and a former president of the Danish Red Cross.

APPOINTMENT IN REGULAR ARMY MEDICAL CORPS

The Chief Surgeon, Far East Command, has recently received encouraging information that many of the reserve medical officers on duty in this command have evidenced interest in becoming members of the Regular Army Medical Corps. This article furnishes pertinent information regarding eligibility for appointment, grade determination, preparation and submission of application, and a brief description of the Graduate Professional Education Program sponsored by the Army Medical Service.

Each applicant for appointment must meet the requirements set forth in SR 605-25-10, which are briefly: be a citizen of the United States; be physically qualified; not be a conscientious objector; have reached 21st birthday but not have passed 32nd birthday on date of appointment as first lieutenant, 37th birthday on date of appointment as captain, 42nd birthday on date of appointment as major, and 48th birthday on date of appointment as lieutenant colonel; be a graduate of a medical school acceptable to the Surgeon General, conferring the degree of doctor

of medicine; and have had, subsequent to graduation, served internship acceptable to the Surgeon General, or its equivalent in practical or professional experience as determined by the Surgeon General.

Appointment in the Medical Corps will be in the grade determined by the applicant's age and active professional practice, excluding internship, but including residency and post-graduate training, as follows:

	Medical Professional Practice	Maximum Age
First Lieutenant	None	32 Years
Captain	3 Years	37 Years
Major	10 Years	42 Years
Lieutenant Colonel	17 Years	48 Years

Each individual appointed in the Regular Army under the Officer Personnel Act of 1947 (61 Stat. 795, Sup III), as amended, shall at the time of appoint-

ment be credited with an amount of service equivalent to the total period of active federal service performed after attaining the age of 21 years as a commissioned officer in the Army of the United States subsequent to 31 December 1947 and prior to appointment in the Regular Army, but not to exceed 5 years.

Applications may be submitted at any time on DA AGO Form 62 (Application for Appointment as a Commissioned Officer in the Regular Army), in duplicate, by individuals who meet the above requirements for direct appointment. Applications must be accompanied by DD Forms 98 and 98a (Loyalty Certificate for Personnel of the Armed Forces) and a recent photograph, head and shoulders type, not smaller than 3 by 5 inches, with applicant's name and current army service number printed on the reverse side.

Medical Corps Officers on duty in the Far East Command who desire appointment in the Regular Army should submit applications to their immediate commanding officer, who will forward the original and inclosures through military channels to the Commander-in-Chief, Far East Command, APO 500, and the duplicate copy to The Adjutant General, Washington 25, D. C., Attention: AGSO-R.

Upon receipt of the original application and inclosures, the Evaluation Board at Headquarters, Far East Command, consisting of at least three senior officers of the Medical Corps, will establish a date mutually agreeable to all concerned for the appearance of the applicant before the board, and in due time orders will be published by appropriate commanders placing the applicant on temporary duty with the Medical Section, Headquarters, Far East Command, for this purpose.

Applicants are required to submit evidence of internship and degrees to the Evaluation Board which will determine whether or not the applicant fulfills the general eligibility requirements as prescribed by AR 605-25. No written professional examination will be required of any applicant.

After the applicant's appearance before the Evaluation Board, proceedings, findings and recommendations will be recorded on the prescribed forms and forwarded to the Department of the Army for review and final action. Normally, the applicant receives notice of appointment or non-appointment within 120 days after appearance before the board.

Young physicians will do well to weigh carefully the superior advantages in professional attainment which the Regular Army offers in its Army Residency Program. This program provides physicians and surgeons of the Regular Army with opportunities for progressive medical education and training in splendid facilities with a wealth of clinical material. Residencies in practically every phase of medicine and surgery are offered and the high standards of training comply fully with those established by the appropriate civilian councils and boards.

The Graduate Professional Program has dual aims: to develop to the maximum the professional ability of all Army Medical Corps officers, and to provide the required specialists in the various fields of medical practice to meet the needs of the Army. Training begins with internships in the Army's general hospitals, and continues through residencies in practically every specialty, plus clinical physicians (mixed) residencies. Beyond that, qualified individuals

may be sent to a wide variety of civilian institutions for specific training.

The Surgeon General has developed this program with the advice and cooperation of the Council of Medical Education and Hospitals of the American Medical Association, the American College of Surgeons, the Advisory Board to the Specialties, the various American Specialty Boards, and the Association of American Medical Colleges.

The excellent physical facilities of the larger Army general hospitals and the great variety of clinical material lend themselves admirably to the operation of such a program. The professional staffs of the teaching hospitals are materially strengthened by the services of recognized civilian specialists. These factors, integrated into the over-all pattern of the programs, have produced an ideal organization for graduate medical training.

The Graduate Professional Education Program is in operation at the following Army hospitals:

	Total Beds
Army and Navy General Hospital	460
Hot Springs, Arkansas	
William Beaumont Army Hospital	750
El Paso, Texas	
Brooke Army Hospital.....	2,000
San Antonio, Texas	
Fitzsimons Army Hospital	2,500
Denver, Colorado	
Gorgas Hospital	705
Panama Canal Zone	
Letterman Army Hospital	1,525
San Francisco, California	
Madigan Army Hospital.....	1,100
Tacoma, Washington	
Tripler Army Hospital.....	1,200
Honolulu, Hawaii	
Walter Reed Army Hospital	1,600
Washington, D. C.	

Each of these hospitals is fully equipped with modern laboratory, surgical, radiological, library, and other types of medical facilities, and for the most part are housed in large modern buildings designed to meet the needs of hospital operations. With few exceptions they are located in the vicinity of civilian medical teaching centers.

Medical officers desiring residency training should apply through channels to The Surgeon General, U. S. Army, Washington 25, D. C., Attention: Personnel Division. Selections are made in April of each year for assignments to begin 1 July of the same year. Regular Army Medical Corps officers are eligible to apply at any time for such training. Medical Corps officers, other than those of the Regular Army, are required to submit application for appointment in the Regular Army along with their application for residency training.

In a recent communication to the Chief Surgeon, Far East Command, the Surgeon General stated that his office has kept faith with those who entered the Regular Army with the expectation of receiving professional training. In spite of the large demands placed on the Department of the Army for Medical Corps officers to support the war effort in Korea, it has this year wiped out the major portion of the backlog of Regular Medical Corps officers who have applied

for residency training. There will, therefore, be some 100 odd spaces next year for those who now apply for a commission in the Regular Army. Veterans of the Far East Command will have high priority in this program.

Many Medical Corps officers on duty in the Far East Command came into the military service direct from a civilian residency, and it is assumed that they expect to return to that residency after the completion of their tour of duty. The Surgeon General is most desirous of knowing whether any of these medical officers would be interested in a Regular Army commission, provided they could be reentered as medical of-

ficers in their civilian residences. Priority here would be given to those who have completed all but one year of their training. Officers in this category who are interested in applying for Regular Army commissions should make their desires known by letter, through military channels, to The Surgeon General.

Individuals interested in securing additional information regarding the application and appointment of officers in the Regular Army Medical Corps are urged to direct their inquiries to the Chief Surgeon, Far East Command, APO 500.

RECENT DEPARTMENT OF THE ARMY AND FEC PUBLICATIONS

AR 40-506, C-5, 21 Mar 52: Medical Service - Persons Eligible to Receive Medical Care at Army Medical Treatment Facilities

AR 40-610, C-2, 26 Mar 52: Medical Service - General Administration of Medical Treatment Facilities

AR 40-680, 7 Apr 52: Medical Service - Length of Hospitalization and Disposition of Patients

AR 220-315, 11 Apr 52: Field Organizations - Unit Awards, Sec IV - Infantry and Medical Streamers

SR 140-105-9, C-2, 6 Feb 52: Organized Reserve Corps - Appointment in Army Medical Service Sections of Individuals Registered under Selective Service Act of 1948, as amended

SR 711-45-13, C-1, 7 Feb 52: Stock Control - Supply Status Reporting System - Army Medical Service List of Reportable Items of Property

SR 40-930-1, AFM 160-7A, C-1, 25 Feb 52: Medical Service - Veterinary Food Inspection

SR 605-60-44, C-2, 4 Mar 52: Officers - Dental Officer Procurement - Dental Military Intern Program

SR 615-220-50, 4 Mar 52: Enlisted Personnel - Selection Criteria for Assignment to Fort Churchill, Canada

SR 605-60-52, 5 Mar 52: Officers - Women's Medical Specialist Corps Procurement - Occupational Therapy Course

SR 605-60-43, 7 Mar 52: Officers - Medical Officer Procurement - Professional Training Program

SR 730-90-26, 18 Mar 52: Oversea Supply - Army Medical Service Items Required in Continental United States

SR 40-505-13, 19 Mar 52: Medical Service - Medical Care in Naval Medical Treatment Facilities

SR 40-1025-40, 28 Mar 52: Medical Service - Preparation of Medical Report Cards (WD AGO Forms 8-24) For Patients Processed for Separation by Physical Evaluation Boards or Recalled for Periodic Physical Examination

SR 140-180-5, C-1, 3 Apr 52: Organized Reserve Corps - Retirement Point Credits for Personnel

SR 711-45-13, C-2, 4 Apr 52: Stock Control - Supply Status Reporting System, Army Medical Service List of Reportable Items of Property

SR 600-560-6, 16 Apr 52: Personnel - Disposition of Personal Property (Effects) in Theaters of Operation

DA Cir 5, 15 Jan 52: (Corrected Copy) - Sec IV - Distribution of Pamphlets

DA Cir 9, 29 Jan 52: Hospital Fund Food Service and Welfare Economies, Fiscal Year 1952

DA Cir 10, 31 Jan 52: Sec VI - Management Training For Officers, Sec IX - WD AGO Forms 8-225 and 8-226 (Clinical Record)

DA Cir 17, 3 Mar 52: Sec I - Allergenic Extracts (Medical Stk Nr 1-582-900 thru 1-583-207); Sec III - Medical Treatment in Army Medical Facilities, Fiscal Year 1952; Sec V - Terramycin Hydrochloride For Aqueous Injection, 0.25 Gm (4 Gr) (Medical Stk Nr 1-610-600)

DA Cir 26, 1 Apr 52: Sec II - Denture Identification; Sec III - Dental Roentgenogram Disposition; Sec IV - Penicillinase, 1000 Units; Sec VIII - Utilization of Water Sterilizers in Army Medical Treatment Facilities

DA Cir 28, 15 Apr 52: Sec III - Utilization of Water Sterilizers in Army Medical Treatment Facilities; Sec VI - National Service Life Insurance

ATT 8-20, 11 Mar 52: Training Test for Medical Company Infantry Regiment (T/O&E 8-7N)

T/A 8-100, 27 Nov 51: Allowances of Medical Expendable Supplies

T/A 20-130-FEC, C-2, 11 Dec 51: Japan Occupation Area

TB MED 230, 21 Jan 52: Management of Venereal Diseases

TC 8, 25 Feb 52: Professional Services (T/O&E 8-500, Part IV)

T/O&E 6-535, 1 Jan 52: Field Artillery Battalion (280-MM Gun) Designation: _____ Field Artillery Battalion; Medical Detachment, _____ Field Artillery Battalion

T/O&E 8-187A, 28 Dec 51: Medical Depot (Communications Zone)

GHQ FEC Cir 8, 28 Jan 52: Officers' Voluntary Category Statements for Retention on Extended Active Duty

GHQ FEC Cir 10, 7 Feb 52: Disposition of Personnel Records and Military Pay Records of Casualties, Deserters, and Medically Evacuated Personnel

GHQ FEC Cir 14, 7 Mar 52: Immunization

GHQ FEC Cir 16, 13 Mar 52: Escort of Remains

GHQ SCAP Cir 5, 10 Mar 52: Control of Entry and Exit of Individuals, Cargo, Aircraft, and Surface Vessels Into and from Japan

HQ FEC Cir 2, 29 Apr 52: Records Administration

TECHNICAL

The Value of Early Psychiatric Treatment	57
Acute Opium Intoxication	60
Incidence of Parasites in United Nations Patients Returning from Korea	60
Case Histories: Epidemic Hemorrhagic Fever.	61

THE VALUE OF EARLY PSYCHIATRIC TREATMENT*

Lt Colonel Lucio E. Gatto, USAF (MC)

THE RECOGNITION of physical disease in its earliest stages is a goal toward which all physicians constantly strive. Campaign after campaign for the recognition of such diseases as cancer indicates that the laity too is oriented toward this goal. Early treatment instituted on this basis really saves lives and prevents suffering.

The recognition of disturbed human behavior, on the other hand, in its early stages, is still a difficult goal for many of us to attain. These problems, too, need early treatment. Very often, even in the face of frank emotional distress, many of us are too prone to feel that an individual can or should cure himself. Statements that "one can conquer one's feelings," "that will power can conquer anything," or that one "can force oneself to get well or change," implies a too commonly held belief that only the emotionally weak or mentally unsound find it difficult to face emotional problems. For these reasons individuals with severe emotional and personality problems rarely reach the psychiatrist in time to make their treatment easier. Psychiatric therapy is all too often instituted as a last measure. It often is looked upon by the patient as a "stigma" and often viewed by the doctor as a technique for threatening the patient into getting well. To be seen by the psychiatrist is too often conceived as a threat of impending insanity. The defense of "a flight into health" utilized by a patient fraught with emotional difficulties when the doctor advises psychiatrist treatment is well recognized in psychiatric understanding. This flight into health or apparent improvement is too often of only short duration.

Superficially, the resistance to early psychiatric assistance is usually based on some of the following ideas:

An intelligent individual should be able to handle and control all his emotional reactions. One patient stated: "If I can't control myself or handle my job, I'm washed up and useless. I'm not worthy of a person's respect or confidence. I must work out my own problem." This reaction might well be compared to the patient with an early pneumonia or appendicitis who feels he can cure his own disease. Sometimes it works. Most of the time it does not. The individual should recognize that many intelligent people react adversely to their emotions. How much one's actions are motivated by illogical, emotionally tinged attitudes is well expressed by the patient who said, "I know what I'm supposed to do and what's best, but for some unknown reason, I just find myself doing just the opposite." This action is not always "willful."

The idea that everyone who goes to a psychiatrist must be insane, mentally deranged and out of his mind. This is well expressed by an intelligent officer who actually came in only after great hesitation and asked, "Do psychiatrists ever treat anything other than mentally disturbed people (psychotics) or people who get into trouble with authorities (delinquents and psychopaths)?" He seemed totally unaware that the examination and treatment of psychotics and psychopaths represent only a small proportion of a psychiatrist's work. Psychiatrists are chiefly concerned with many reality problems obscured by individual's emotional attitude. These include attitudes toward work, marriage, love, the expression of aggression in varying environmental situations. Disturbed feelings, anxieties and aberrant behavior which render people unhappy and annoy others do not always mean mental derangement.

There is a common belief some people have that anyone can help a disturbed person if that person will only tell his problem to anyone, no matter how unskilled the listener may be. How common this is is difficult to determine, but imagine the reaction of a patient who told of his experience with a superior NCO, who drew him into his room and said, "Tell me all about your life. I'll analyze your problem and you'll be all right." This belief also includes individuals burdening their best friends with severe emotional problems. Psychiatry and analysis are not to be carried out by the unskilled anymore than a patient with appendicitis would go to a butcher for surgery, even though he too wields a knife.

Many individuals in positions of leadership feel that logic will provide individuals with solutions to their problems but too often they find this does not work. They should recognize that except for basically simple emotional problems, very often an individual does not recognize the true reasons for his anxiety or the presence of conflicting emotional attitudes within himself. They may recognize the turmoil within themselves, but as to the "why", they usually have no ready answer. It would be wonderful if everyone could recognize himself when he needs emotional assistance and tell exactly why he behaves as he does. One should view this situation exactly as in physical disease. The patient recognizes something is wrong within himself and he tries simple measures. If these fail he should then turn

to the skilled physician for help. Too often in emotional situations, some deeper force holds the person under its control and keeps him in a state of "unfreedom," which prevents him from doing, seeing, thinking, or reacting in a way that is proper and acceptable.

Many an individual is justifiably proud and rightly so of his ability to handle and control people. This capacity for aiding people in their problems by giving advice, counselling assistance, and disciplinary

control, is commendable and of great value in many instances. This success with the many under an individual's leadership or care should make it easier for him to recognize that something is wrong when his methods fail. If skill in counselling or discipline fails to produce a favorable response in certain individuals who have intelligence, ability, and a desire to do better, other action is important.

A doctor who finds that his medication or treatment is not helping his patient's physical distress, should not feel annoyed or that his patient is not cooperating. Failure to find cause for physical symptoms should not, however, lead to the conclusion that the patient is malingering. In both instances, the problem may need more specialized handling. The doctor must recognize the borderline at which common sense and counselling fail because they meet emotional barriers that may require as specialized discriminating scientific psychiatric understanding as an acute surgical abdomen needs the skill of a trained surgeon. He must judge for himself when his actions and technique have failed to alleviate his patient of physical complaints which may indicate underlying serious emotional disease.

He must be cognizant that just a single symptom such as vomiting can have many etiological causes from which he must pick the actual cause, that disturbed behavior or complaints of physical illness, not supported by factual organic disease, too have multiple causes.

Emotional conflicts and personality disturbances can be expressed in many ways. One individual's choice varies from the next. The same conflict may be solved by individuals in (1) a normal way acceptable to society, (2) by neurosis, (3) by psychosis, (4) by delinquency, and (5) psychosomatic complaints and disturbances.

Delinquency itself in the military service can be looked upon superficially as a simple act of wrong doing requiring disciplinary action. To lose sight of the fact that an act of delinquency may be the result of the various types of delinquency which include normal delinquency, immature delinquency, neurotic delinquency, mentally-deficient delinquency, or finally, psychotic delinquency, can cause gross errors in treatment.

One must become fully aware that the basic motivation for behavior is not always recognizable, visible, or usually available to the patient for direct disclosure. For a commanding officer or a doctor to feel that exhortation, suggestion, will power, or discipline should produce excellent results in all cases, is to forget that motivating causes are not always easy to evaluate or control. Psychiatry recognizes that motivation, defined as a drive to obtain satisfaction of certain underlying needs produces three types of behavior: (1) Conscious, (2) Automatic, (3) Unconscious. All three types may be active simultaneously in the same person at the same time. The quantity of each usually determines the external characteristics of this behavior. To say that the driving force in a person to accomplish something, and receive satisfaction, is always conscious, willful, is not acceptable. To want a glass of water and to get it is based upon conscious motivation. For trained soldiers to react reflexively with good economical defensive measures against actual threatening dangers in combat usually represents behavior acting upon an automatic motivation,

in that learning has minimized conscious reaction. However, when certain types of behavior are adopted against either unreal dangers and for no apparent good or logical reasons, it does not hold that conscious motivation is present. Often the person is unaware of the hidden forces which unbeknown to himself, drive him to feel and do things that he would certainly avoid if in full possession of his will.

"Unconscious" motivation thus really causes the individual to interpret and respond to situations in accordance with deeper attitudes both unrecognized by himself and unexplainable to others. Often this unconscious, motivating force is unpredictable, capricious and contradictory. The individual cannot explain the why of his behavior because he is not aware of its meaning. For example, an Airman had developed "a defensive-offensive" attitude toward everyone around him. He absolutely had no self-knowledge that he was inciting resentment and criticism in others by his own behavior. During psychiatric investigation it became apparent that he had adopted this irritating attitude early in life in relation both to his father and brother who constantly goaded him to fight back because he felt inferior and incapable. For him to maintain this attitude throughout life had not only been unnecessary but harmful to him since it actually resulted in punishment or in failure for his advancement.

While the casual observer can recognize this proverbial "chip on the shoulder" attitude, he can neither understand its cause nor can he usually produce a change by telling the person about it. Very often the possessor of this unrecognized unconscious and irrational behavior remains completely in the dark concerning his behavior until a properly trained examiner can bring it into view cautiously and with proper understanding. Realistic understanding of this domination of individuals by deep forces can ordinarily be attained only by long training and experience. If the causes for disturbed behavior are difficult to recognize, psychiatric assistance should be obtained early. Examples of waiting too long include the following:

a. A 20 year old Airman who rose rapidly to the position of senior cook was doing a superior job in Korea. Gradually he developed headaches, marked irritability, and a loss of interest. Despite intensive physical investigation, no cause for his complaints was found. From a highly capable individual, he went from cook to furnace man to truck driver, still with headaches and a feeling of disinterest. Reassurance, exhortation, suggestion all failed to help. He admitted consciously he did not like being in Korea anymore than anyone else, but he had completed over half of his required service. He had married several months prior to coming to Korea, and his wife was having many difficulties, but he stated that he had accepted his situation. Gradually, with no improvement in his physical feelings, he became distant and somewhat withdrawn. It was only when he was finally brought in for psychiatric assistance, that it became apparent that he had never been able to accept or trust people. When he felt troubled he always isolated himself emotionally from others, even from his family. Since he had not learned to participate and become part of a group, or to rely on others around him, or place some degree of trust in his fellow workers, he was constantly under a tension he could not understand. In the meantime, six months had passed, and he was functioning far below his level. When these deeper dissatisfactions were pointed out in conjunction

with his conscious longing for home and his wife, he was able to give up his non-gratifying hyper-independence which was really an isolation and learn to trust others. He recovered from his symptoms, became sociable and made friends, and had again learned to become part of his group.

b. A serious-minded, quiet, S/Sgt worked quietly, unobtrusively but did excellent work. Gradually he became more withdrawn and he was noted to spend several hours nightly sitting talking to no one and often staring into space. He remained retiring and depended completely on one roommate to prod him into activity. It was only after he made a suicide attempt that people recognized he had been odd. No one had recognized his earlier actions as having meaning.

c. An officer with a long tour of duty in Korea, faced with many internal conflicts and family problems, "escaped" them by continuous over application to his work. He became anxious and disturbed. He made wrong decision after wrong decision. It was only after several months of mental anguish that he was sent for psychiatric assistance where he learned to face his problems with proper understanding of his emotional tensions. An earlier understanding would have prevented both wrong decisions and his mental anguish.

d. An immature air policeman constantly found himself so much in conflict with his fellow soldiers that he frequently met with reprimands from his superiors. His defense against this was to seek refuge in minor physical complaints. Instead of these complaints being recognized as a screen for deeper emotional problems, they were used to point out that he was malingering. Disciplinary action and repeated rebuffs only served to fix his symptoms until he developed a severe conversion reaction. One medical officer had indicated as therapy, "all he needs is a good sock on his noggin." When this patient finally received psychiatric therapy for his conversion reaction, it took a long time to relieve him not only of his paralysis, but a longer time to remove his distrust and suspicion, and restore his attitudes to a normal outlook. Early recognition and treatment might have made him of value to the service.

These examples indicate psychiatric help came much too late. Individuals were hurt just as much as if they had an untreated physical disease. One should realize that one must not wait for changes in individuals to be gross. Much like a cancerous growth, the emotional conflict, if too deeply rooted, may take so much a toll of the patient's reserve and strength, that the work required to reclaim such an individual becomes extremely difficult. This is true especially of individuals who utilize alcohol as an escape from severe depression and conflict. A senior Staff Sergeant, with 15 years of service, worked long hours in his position in the Inspector General's Office. Partly because of this and frequent traveling, he made only a few strong ties with his fellow airmen. He drank alone and brooded almost constantly, but no one seemed to take this as unusual. It was not until he left a bizarre note with his C.O. which indicated intentions of self-destruction, that he was brought to the attention of the psychiatric department. Treatment at this time was indeed difficult. To wait for a person to have an open break with reality before treatment is instituted is bad medicine. The psychiatrist is faced with a problem much like the surgeon who opens

an abdomen to find an extensive cancer invading many organs. When a patient's emotional conflicts have invaded his entire personality structure, and broken through and distorted his normal defense, treatment becomes arduous.

All individuals who arrive in Japan from the United States go through a period of adjustment. When this adjustment shows a stormy course, the understanding superior will, if ordinary procedures fail to bring about a good adjustment, seek further understanding of the situation.

If the doctors and interested superiors and supervisors will remember that the psychiatrist deals not only with cases of frank mental derangement and misfits, but chiefly with all problems involved in making an adjustment to life in general, work, sex, and varying environmental situations, the proper understanding of the role of the psychiatrist becomes more recognizable. For a truly practising psychiatrist, over 90% of the individuals who come to him, come for an understanding of the latter type of problems and not because of psychosis or inability to fit into the standards of his society whether it is military or civilian.

The general medical officer in dealing with such individuals still may use reassurance, understanding, sympathy or exhortation, and his own special brand of psychotherapy. He should encourage his patients to talk freely about their feelings and annoyances. When this fails, early psychiatric assistance may produce gratifying results. This does not mean that the medical officer is expected to send every diagnostic medical problem for psychiatric evaluation indiscriminately. He should still give therapy to emotional problems in many instances, but as soon as he recognizes that his therapy causes little changes, psychiatric study should become imperative.

In combat, suggestive, exhortative and directive methods of appealing to the patient's sense of responsibility, patriotism and self-respect become important due to the exigencies of the situation. In psychiatry outside of combat areas, such procedures often fail. The medical officer must not be loath to seek psychiatric advice. "I gave him various drugs, reassurances, suggestion, everything I could think of, but to no avail," wrote one medical officer. The patient expressed his reaction to this therapy, "I had become a flying pharmacy loaded with medicine but I couldn't understand how my sickness could be imaginary." We should not wait until medical treatment reaches the point of "to no avail." Psychiatry and its treatment methods should not be "last resort" measures but an active form of preventive medicine much like industrial medicine which now is properly focused for recognizing the need of protecting workers from deleterious chemicals and unhealthy working conditions.

While the psychiatrist definitely should not be viewed as though he is a miracle worker, who can by mystic procedures or magic, remove the patient's troubles and remake personalities overnight, it should be recognized that his evaluation of patients and treatment is based upon sound, scientific understanding. The psychiatrist is not just a counsellor, or father confessor or one on whom the patient can lean and from whom he can receive sympathy. The psychiatrist examines and evaluates his patient in reality and uncovers the various motivations for use by himself and his patient whom he guides in making choices and readjustment. While a surgeon's movements and

results show concretely, the psychiatrist must work with non-visible but still actual realities of feelings and conflicts. His scientific observations of people's behavior may often be just as incisive as the surgeon's knife. His understanding of the meaning of an individual's thinking, feeling and actions in reality are based upon a knowledge of deep motivation and drives which the patient usually does not recognize. He expects resistance, verbal and otherwise, from his patient, and even temporary increases in anxiety and resentment as the patient's abnormal defenses are dissected or revealed. But he knows he must approach the patient's problem cautiously and properly. He does not overwhelm the patient with the anxiety from which the patient has escaped by building abnormal defenses. With good understanding he develops a course of action with the patient which should release the patient from inhibiting inefficient and self-punishing devices. Many who require such help, respond well, especially if given an early opportunity for psychiatric understanding. With proper guidance these individuals later build better and

more adequate techniques for handling their problems themselves.

The role of the medical officer is to recognize these problems early and to refer them for help as soon as emotional factors are recognized which do not respond to his therapy. The patient may resist at first since he cannot recognize the meaning of his poor understanding and utilize the procedure which best fits the patient's needs.

In the final analysis, the best results in aiding individuals along the road to better emotional and physical health are for his co-workers, supervisors, and medical advisors to recognize the true aspects of his problem as early as possible in order that the proper course of action, whether it be psychiatric or physical, may be taken. Preventive Psychiatry plays an important role in the daily emotional life of the individual as preventive sanitary measures in his physical health. Both protect the individual from harmful agents that can destroy him.

ACUTE OPIUM INTOXICATION

The problem of opium addiction has become important in the Far East Command. Consequently, acute opium intoxication is a medical emergency more likely to be seen. The opiate locally available is heroin, which can be purchased inexpensively in a 95% pure form. The classical triad in acute opium intoxication consists of coma, depressed respiration, and pinpoint pupils. With varying degrees of intoxication the clinical picture is altered, and stages from marked agitation to rapid loss of consciousness may be seen.

Therapy of acute opium intoxication should be directed at maintaining the respiratory system. Respiration is maintained by artificial respiration, if necessary, and by such stimulants as coramine and caffeine with sodium benzoate. Coramine can be given intravenously as a 25% aqueous solution in doses of 3 to 5cc at intervals of 5 minutes if necessary. Other stimulants appear to offer no advantage over the use of coramine or caffeine.

Even more important in treatment is the continuous and intensive oxygen therapy which should be given these patients. The pulmonary edema which is frequently seen in acute opium intoxication interposes a barrier to respiratory gas exchange. This serves to increase the anoxia already caused by the depression of the respiratory center. Vigorous oxygen therapy overcomes this barrier. If the ventilatory and respiratory functions are thus maintained, there

is every opportunity for recovery without sequelae from even deep coma. Circulatory collapse is a very late event and is secondary to the anoxic anoxemia caused by the respiratory involvement.

The pulmonary edema of acute opium intoxication appears to be due to a direct irritative effect. There are few signs on physical examination except for the cyanosis. The edema is probably chiefly interstitial in nature. At times a marked alveolar component is present and the patient raises bloody sputum. The latter may give rise to problems of differential diagnosis.

Acute opium intoxication due to intravenous administration usually presents a more sudden and severe picture. The pulmonary edema may be more marked, requiring even greater attention to the use of oxygen—usually by mask and, even better, under positive pressure. It is important to maintain a high index of suspicion for acute opium intoxication. Prompt, appropriate therapy will be amazingly successful in even moribund appearing patients.

Other aspects of treatment, in addition to oxygen and respiratory stimulants, should not be forgotten. These include maintenance of a clear airway, change in position, and preservation of body temperature in the comatose patient. Prophylactic chemotherapy is indicated.

INCIDENCE OF PARASITES IN UNITED NATIONS PATIENTS RETURNING FROM KOREA Lt Colonel Clara Raven, MC, 279th General Hospital, APO 53

All patients admitted to this hospital, regardless of the diagnosis, have stool specimens sent routinely to the laboratory to be examined for parasites. From May 1, 1951 to March 31, 1952, stool specimens from 2,592 patients were so examined. Approximately 95% of these patients were evacuees from the Korean front. The method used was that described by Ritchie and used at the 406th Medical General Laboratory (Ritchie, L.S. 1948. Bull. US Army Med Dept 8 (4); 326). No effort was made to estimate the intensity of infestation. Three well trained technicians per-

formed the examination in this survey. Each stool specimen was checked by at least two technicians. The results of this survey are indicated in the following table:

	Number	Percentage
<u>Helminth Infestation</u>		
Ascaris Lumbricoides	272	10.4
Hookworm	150	5.7
Trichuris Trichiura	180	6.9

	Number	Percentage
Strongyloides Stercoralis	33	1.2
Shistosoma Mansonii*	3	0.1
Hymenolepis Nana	2	0.07

Protozoa Infestation

E. Histolytica	136	5.2
E. Coli	275	10.5
E. Nana	249	9.5
G. Lamblia	91	3.5
I. Butschlii	28	1.0
C. Mesnili	6	0.2

*The three patients having Shistosoma infestation were Puerto Rican.

Additional data just recently in progress of collection, such as length of service in Korea, the exact location in Korea, forward or rear areas, the period of contact in each area, race, home state, etc., would give more revealing data and perhaps increase the incidence. Nevertheless, the figures are significant. The above data apparently indicates that parasitic infestation in US troops evacuated from Korea does not assume the magnitude one would expect in men subjected to the unsanitary conditions there existent.

CASE HISTORIES: EPIDEMIC HEMORRHAGIC FEVER



The following are case history reports on Epidemic Hemorrhagic Fever treated by officers of the Medical Service, 22d Evacuation Hospital (SMBL), APO 301. The hospital is commanded by Colonel John G. Baxter, MC.

Case History #1: A 27-year old white soldier who arrived in Korea 25 September 1951, had been in good

health until 17 November 1951 when he noticed a generalized headache (not retro-orbital). That same evening he had chills, fever, and myalgia. He reported to an aid station where he was reported as having a temperature of 104 degrees F., and a hordeolum of the left upper eyelid. He received 300,000 units of penicillin. His temperature persisted, and he was evacuated through various medical facilities to the Eye Service of the 22d Evacuation Hospital, arriving on his 4th day of illness. Two days prior to his admission to this hospital he began to have retro-orbital pain. The following day he had a small hemorrhage from the nose which was stopped by local pressure.

Past History: Negative, except for history of influenza and appendicitis.

Physical Examination: The 5th day of illness revealed a well developed and well nourished white male appearing acutely ill. His temperature was 105 degrees F., pulse rate was 110, and his respiration rate was 20. The face, neck, and upper part of the chest were flushed. The skin was hot and dry, but entirely free from petechiae. The conjunctival vessels were injected. The left upper eyelid was injected and swollen, but there was no evidence of a hordeolum. Minimal peri-orbital edema was present. The nasal passages were crusted and dry. The throat was normal. The chest was clear to percussion and auscultation. The heart showed regular rhythm, no murmurs, and was not enlarged. The blood pressure was 120/70. Examination of the abdomen was normal. There was no lymphadenopathy. A tourniquet test was markedly positive.

Initial Laboratory Findings: The urine was normal except for a trace of albumen. Complete blood count revealed the WBC to be 8,400. The differential was as follows: 77% neutrophils with 22% segmented forms, 44% band forms, and 10% juveniles. There were 2% eosinophiles, 14% lymphocytes, 4% monocytes, and 4% atypical lymphocytes.

Course in Hospital: A diagnosis of Epidemic Hemorrhagic Disease was made, and the patient was transferred to the Medical Service. The patient was started on aureomycin, 500 mgms every four hours. A lumbar puncture revealed an opening pressure of 240 millimeters of spinal fluid. This fluid was clear, and contained 2 lymphocytes. Total protein was 35 mgms percent. The Wasserman was negative, and the gold curve was flat. A transfusion of 500cc of non-convalescent fresh whole blood was given on the day of admission, the patient's 5th day of illness, without incident. On the 6th day of illness, axillary petechiae were noted. He began to vomit clear fluid so the aureomycin was discontinued. The temperature dropped to 99 degrees F., and rose again to 102 degrees F. The platelet count was 12,000 per cubic millimeter.

On the patient's 7th day of illness, the temperature dropped to normal, and the patient became critically ill. He vomited frequently, and on three occasions small amounts of blood were present in the vomitus. He complained of persistent abdominal pain and had bouts of hiccoughs lasting ten minutes to three hours. The blood pressure fell to 80/60, and at times was unobtainable. The patient showed gradual improvement following administration of 500cc non-convalescent fresh whole blood and intravenous fluids.

The patient was oliguric from the 6th through the 11th day of illness and was anuric on the 12th and 13th days. On the 14th day a profound diuresis began. A maximum NPN of 240 mgm percent was reached. During the period of diuresis, the patient was given additional potassium chloride and sodium chloride.

On the 21st day of illness, the patient was enjoying a full diet and sitting up in a chair for short periods. (Major David S. Burnet, MC)

Case History #2: Chief complaints were chills, fever, headache of 24 hours duration.

Present Illness: Twenty-four hours prior to admission to the Medical Service, 22d Evacuation Hospital, this 27-year old white male soldier suddenly developed high fever, repeated shaking chills, severe generalized headache, retro-orbital pain, photophobia, low back pain of moderate severity, and generalized myalgia and arthralgia. There was no history of vomiting, cough, sore throat, chest or abdominal pain. The patient had served in Korea continuously for the past twelve months. Three weeks before admission, he noted several punctate lesions in the right inguinal region which he interpreted as insect bites.

Physical Examination: Temperature 102 degrees F., pulse rate 104, respiration rate 20, blood pressure 112/70. The patient appeared acutely ill. Slight bilateral conjunctival injection and a flush involving the face, neck, shoulders, upper chest and back were the only positive findings. There were no petechiae, conjunctival hemorrhage, stiffness of the neck or demonstrable enlargement of the liver, spleen or kidneys.

Hospital Course: During the first three days of hospitalization, a high fever of the remittent type was present with frequent shaking chills. Admission laboratory findings were leukopenia and negative urinalysis. The patient developed no new symptoms, however two days later, the flush became more marked, and several petechiae were noted in the left anterior axillary fold, periorbital edema appeared, the Rumpel-Leede test was markedly positive, and urinalysis revealed two+ albuminuria. A diagnosis of Epidemic Hemorrhagic Fever was made. At 1315 hours on the 2d day of hospitalization, patient was given a transfusion of blood from a patient convalescing from Epidemic Hemorrhagic Fever. Ninety minutes later, after 150cc of whole blood had been absorbed, the patient suddenly developed severe shaking chills, cyanosis, rapid and weak pulse, sweating, a drop in blood pressure to 100/70, and emesis of several hundred cc of "coffee-ground" material (subsequent investigation revealed that the patient had received incompatible blood because of an error on the donor's identification tag, and an unsatisfactory cross-matching procedure in the laboratory which did not reveal incompatibility). The transfusion was immediately discontinued, and the patient was immediately given epinephrine and received oxygen per nasal catheter. Later, hyperpyrexia (105.2 degrees F.) appeared, the pulse became slower and stronger, and the patient's color improved. Cortisone was employed in an attempt to combat the serum reaction. Blood pressure during the following two days fluctuated between 80-90 millimeters of mercury systolic, and 50-70 millimeters of mercury diastolic; thereafter gradually increased to a plateau of 120/70 to 130/70 on the 8th day, at which time it became stable.

The patient's general condition deteriorated from the 1st to the 9th days. During this period, he had frequent small hematemesis and oliguria with evidence of impaired renal function. Large confluent ecchymosis appeared over the arms, shoulders, and thighs, and retinal flame-shaped hemorrhages were observed. The patient complained of severe upper abdominal pain and low back pain frequently. During this period, daily intravenous fluids were cautiously administered. On the ninth day of illness the patient had severe epistaxis for several hours. Bleeding time was ninety minutes, clotting time was normal. Because of a marked reduction of the platelet count, 500cc whole blood (fresh) was administered. Although the platelet count remained low following the transfusion, there was no evidence of further hemorrhage or bleeding except for hematuria.

Marked improvement in the patient's clinical condition was noted on the tenth day of illness. Profuse diuresis with disappearance of clinically evident edema occurred during the following three days. Convalescence thereafter was rapid and uneventful. Renal function improved with decreasing albuminuria and hematuria, increasing specific gravity. When evacuated to Japan for further convalescence on the 24th day of illness, he was ambulant for brief periods and asymptomatic except for weakness.

Final Diagnosis: Epidemic Hemorrhagic Fever.

Supplementary Laboratory Data:

20th Day - Trace, B.S.P. retention at 30 minutes
Icterus Index, 6.5 units.
22nd Day - P. S. P. Test:
11% excretion in 15 minutes.
34% excretion in 30 minutes.
53% excretion in 60 minutes.
(Major John R. Gibson, MC)

Case History #3: A 29-year old United States born white male was admitted to the Eye Service of the 22d Evacuation Hospital in November 1951, with a two-day history of burning pain, redness, and purulent discharge of both eyes. Physical examination revealed moderate bulbar and palpebral conjunctival injection of the right eye, and redness, edema, and excoriation of all lid margins with thick purulent crusts. The admitting diagnosis was conjunctivitis and blepharitis, acute, infectious. He was treated with 1% silver nitrate solution, sulfacetamide ointment locally, and chloramphenicol and sulfadiazine by mouth.

During the night of his first hospital day, he developed feverishness, generalized shaking chills, bilateral supraorbital headaches, and anorexia without vomiting, abdominal pain or diarrhea. For several years, he had had a non-productive cough which was unaltered during this present illness. There were no GU symptoms or complaints. These symptoms continued for the next twenty-four hours, and at that time, he was seen by a medical consultant. Physical examination was as follows:

Physical Examination: Well developed, well nourished, white male in moderately acute distress because of shaking chills, alert, cooperative, oriented, without cyanosis or icterus. Temperature, pulse rate, and respiration rate were: 103 degrees F, 106, and 18. His blood pressure was 128/80. Skin: Face, neck and chest flushed. One spider angioma present over the mid-portion of the right scapula. No petechiae or ecchymosis. Nodes: No generalized enlargement. Eyes: Slight injection of conjunctivae and lids with some edema of lids. The pupils were round, regular, and equal, react to light and accommodation. The fundi were normal, without petechiae. Ears: Negative. Nose: Septum deviated to the right with injection of mucous membrane. Mouth: Teeth in good repair. Tongue moist and midline. Posterior pharynx red, without exudate. Gag reflex hyperactive. Neck: Supple, trachia midline, thyroid not enlarged. Chest: Symmetrical with good expansion; lungs, a few low pitched inspiratory wheezes were audible over the upper half of both lung fields, clearing on cough. Heart: Sinus tachycardia; not enlarged, sounds distant, no thrills or murmurs; peripheral pulses good. Abdomen: Ovoid, soft; liver, spleen and kidneys not palpable. No masses or tenderness. Back: No CVA tenderness. Extremities: No clubbing, edema or cyanosis. Neurological Findings: Deep tendon reflexes were equal and active; no pathological reflexes.

Laboratory Findings:

Urinalyses:

Day	Appearance	Reaction	Sp Gr	Albumen	Microscopic
1st	Yellow, clear	Acid	QNS	0	Few epithelial cells occasional WBC.
3rd	Light red, cloudy	Acid	1.028	0	8-10 WBC, occasional epithelial cells.
6th	Amber	Acid	1.022	4+	Granular casts, numerous RBC.

8th	Light yellow	Acid	1.011	4+	15-20 RBC/HPF occasional granular casts
10th	Straw	Acid	1.005	0	Rare RBC, occas- sional epith- elial cell
25th	Yellow	Acid	1.012	0	1-3 WBC/HPF, rare RBC/HPF.

Tourniquet Test:
(Rumple-Leede) - 1st Day: Positive

Chest X-Ray, PA- 1st Day: Negative

Blood Count:									
	WBC							PLATE-	
Day	COUNT	POLYS	LYMPH	BA	EO	MON	HEMAT	HGB	LETS
3rd	5,000	59	40	1					
5th	8,300	77	16	2	4	1			
6th	42,500	69	27		2	2		16gms	Decreased on Smear
9th	7,800	50	50					32	
11th	10,200	56	40		4			12.5gms	
14th	9,700	68	32						185,000
25th	8,800	42	55			3		13gms	
<u>BLEEDING TIME</u>			<u>CLOTTING TIME</u>			<u>CLOT RETRACTION</u>			
5th	2'10"		5' 25"			3 hrs & 45 min			
(Capillary tube method)									

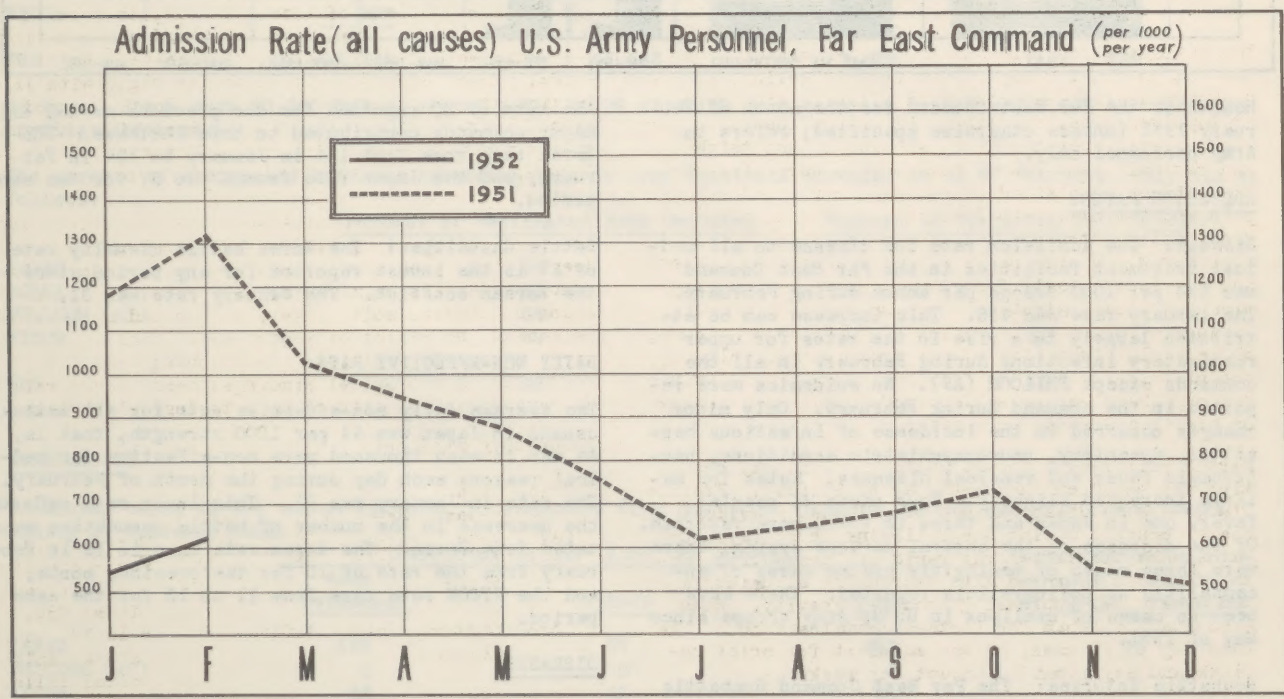
	NPN	CHLORIDES
5th	27.6	
7th	85.5	445.5 mgms percent (as NaCl)
10th	58.6	
13th	75.0	
16th	42.0	
24th	40.0	

Lumbar Puncture:
17th Day - Fluid clear, sugar was 54.1 mgms percent, Wasserman and Colloidal Gold were not reported.

Course: Spiking fever between 99.6 and 104.5 degrees F. continued for four days. During this time, he began to vomit all food and liquids, and had up to eight loose watery bowel movements a day. Both the vomitus and feces were guaiac positive. These symptoms lasted six days. On the fifth hospital day (7th day of illness), 250cc of convalescent whole blood was administered. The temperature became normal the following day, and has remained so. At the time the fever subsided, the patient became oliguric (lowest urinary output was 120cc), and albumin, casts, and red blood cells appeared in the urine. The oliguria persisted for three days. The highest NPN was 88 mgms percent. The lowest blood pressure during this period was 90/60. On the fourth hospital day, several petechiae appeared in the lower conjunctiva of the left eye, and conjunctival hemorrhages were noted on the seventh hospital day. Hemoptysis occurred on the eighth hospital day, and continued for 36 hours. Improvement in all symptoms and signs began about the eleventh day of illness, and has continued to the present time (3rd week of illness). He is asymptomatic at this writing, and physical examination is within normal limits.

Treatment: Treatment consisted of supportive measures, limiting fluids during the period of oliguria, and increasing the intake when the urine volume increased. No conclusion may be drawn as to the effect of the administration of the convalescent whole blood. Penicillin was given daily to prevent secondary infection, and ferrous sulfate was given because of blood loss.
(Captain John M. Glynn, MC)

HEALTH OF ARMY TROOPS, FEC



Admission rates per 1,000 troops per annum, Army personnel, for the four-week period ending 27 February 1952, were as follows:

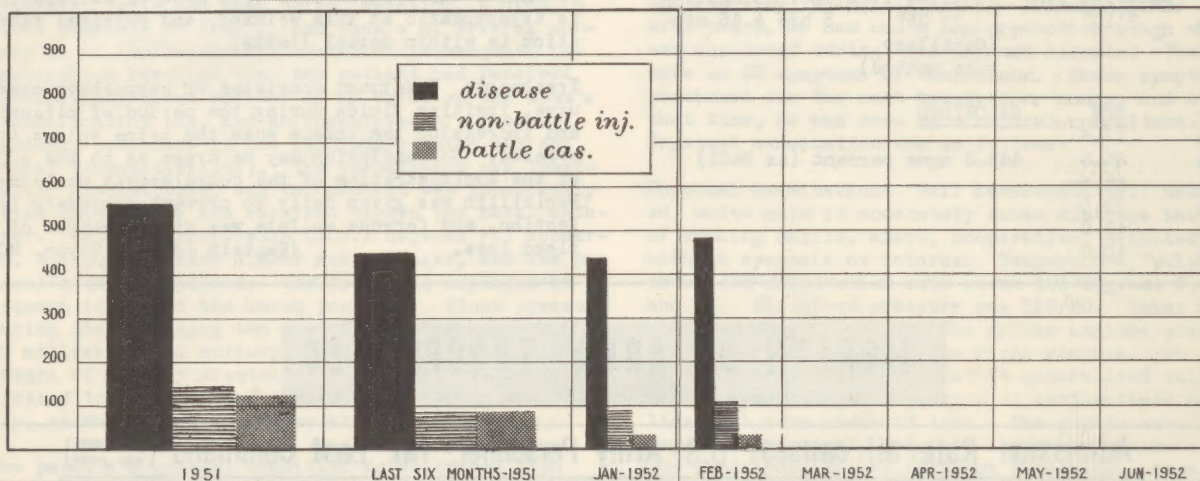
	FEC	JAPAN	KOREA	PHILCOM (AF)	RYCOM
All Causes	608	561	635	280	596
Diseases	488	504	479	240	526
Injuries	103	57	129	40	70
Battle Casualties	17	0	27	0	0
Psychiatric	22	19	23	40	15
Common Respiratory Diseases and Flu	138	174	120	24	149
Primary Atypical Pneumonia	4.9	5.3	5.1	0	0
Bacillary Dysentery	.29	0	.40	0	.90
Amebiasis	1.4	.69	1.8	0	.90
Malaria, new	2.6	1.3	3.3	24	0
Infectious Hepatitis	6.4	5.3	6.9	8	6.3
Dermatophytosis	3.9	4.4	3.4	8	9.0
Rheumatic Fever	.29	.58	.17	0	0
Venereal Diseases	218	258	204	144	143

DAILY NON-EFFECTIVE RATE

All Causes 22 44 12 30 13

admission rates

DISEASE, NON-BATTLE INJURY & BATTLE CASUALTY
(per 1000 per year) U.S. ARMY PERSONNEL, FEC



Health of the Far East Command for the month of February 1952 (unless otherwise specified) refers to Army personnel only.

ADMISSION RATES:

Disease: The admission rate for disease to all medical treatment facilities in the Far East Command was 488 per 1000 troops per annum during February. The January rate was 436. This increase can be attributed largely to a rise in the rates for upper respiratory infections during February in all the commands except PHILCOM (AF). No epidemics were reported in the command during February. Only minor changes occurred in the incidence of infectious hepatitis, dysentery, neuropsychiatric conditions, hemorrhagic fever and venereal diseases. Rates for malaria increased slightly. Four cases of scarlet fever, one in Japan and three in Korea, were reported. Of the diseases of the central nervous system, there were three cases of meningitis and no cases of encephalitis or poliomyelitis reported. There have been no cases of smallpox in U. S. Army troops since May of 1951.

Nonbattle Injuries: The Far East Command nonbattle injury rate of 103 for February is an increase from

the rate of 90 reported for the previous month. All major commands contributed to this increase. The Korea rate rose from 114 in January to 129 in February, and the Japan rate from 47 to 57 for the same period.

Battle Casualties: The Korea battle casualty rate of 27 is the lowest reported for any period since the Korean conflict. The January rate was 31.

DAILY NON-EFFECTIVE RATE:

The average daily non-effective rate for all medical causes in Japan was 44 per 1000 strength, that is, 44 men in each thousand were non-effective for medical reasons each day during the month of February. The rate in January was 52. This lower rate reflects the decrease in the number of battle casualties evacuated from Korea. The Korea rate rose to 12 in February from the rate of 10 for the previous month, and the RYCOM rate rose from 11 to 13 for the same period.

DISEASES:

Common Respiratory Diseases and Influenza: The Far

East Command rate increased from 87 in January to 138 in February. Increases are reported in all commands except PHILCOM (AF), with the sharpest increase in Japan. Of the diagnoses falling in this classification of diseases, 64% were upper respiratory infections, 30% common cold and 5% influenza. Of the cases reported as influenza, only in one instance was the diagnosis confirmed by laboratory tests.

Psychiatric: No notable changes occurred in the incidence of psychiatric conditions. The Far East Command rate rose to 22 in January from 20 for the previous month. The Korea rate of 23 and the Japan rate of 19 each show a gain of 1 point for February.

Infectious Hepatitis: The incidence of infectious hepatitis remains low and there appears to be no evidence that the epidemic which occurred in Korea during the latter part of 1950 and the early months of 1951 is going to be repeated.

Venereal Disease: The rate for "new" venereal disease rose from 214 in January to 218 in February. The rates dropped slightly in Korea and RYCOM, and rose from 227 for the previous month to 258 for February in Japan. The training divisions in Japan tend to hold the Japan rate high. For instance, the rate in February for the 1st Cavalry Division was 460, and for the 24th Infantry Division, 363.

HOSPITALIZATION: (These data cover all patients, Army, Air Force and others).

The bed status as of 27 February 1952 was as follows:

	Designated Beds	Operating Beds	Average Beds Occupied	
			All Patients Army Hospitals	Army Patients USAF Hospitals
JAPAN	13,300	10,980	5,185	205
KOREA	4,500	5,193	2,164	7
PHILCOM (AF)	100	116	54	15
RYCOM	400	344	226	0
FEC	18,300	16,633	7,629	227

In Korea, there were 13,000 PsW operating beds, 7,792 of which were occupied by PsW and 1,564 occupied by civilian internees.

The percent of designated beds and operating beds in Army Hospitals occupied as of 27 February 1952, was as follows:

	Percent of Designated Beds Occupied	Percent of Operating Beds Occupied
JAPAN	39	47
KOREA	48	42
PHILCOM (AF)	54	47
RYCOM	57	66
FEC	42	46

EVACUATION:

Tabulated below is the number of patients evacuated from the major commands during the four report weeks ending 27 February 1952:

	Evacuated to the Zone of Interior			Other United Nations Personnel Evacuated to their Homelands
	Army Personnel	Others	Total	
JAPAN	596	57	653	70
PHILCOM (AF)	0	0	0	
RYCOM	39	12	51	
FEC	635	69	704	70

UNCLASSIFIED



The Chief Surgeon extends an invitation to all Far East Command medical personnel of the U. S. Army, Navy and Air Force, or of the United Nations, to prepare and forward with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted unless author states otherwise.

Capt. Charles A. Copeland, MSC EDITOR

UNCLASSIFIED